



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Jesse O. Schneringer, D. C.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-2025-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

March 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The billing was submitted on time and corrected claims were submitted in a timely manner, please see fax send reports for proof of timely filing. The claim should be paid accordingly."

Amount in Dispute: \$850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor performed designated doctor services and then billed Texas Mutual for date of service 4/16/15. Texas Mutual received the bill, the narrative report, and the DWC69 form. Both the form and report have the exam date as 4/14/15. Because the documentation is inconsistent with the billing Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2015	Designated Doctor Examination	\$850.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for completing a medical bill.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.

- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed.
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions.
- CAC-18 – Exact duplicate service.
- 224 – Duplicate charge.
- CAC-29 – The time limit for filing has expired.
- 731 – Per 133.20(b) provider shall not submit a medical bill later than the 95th day after the date the service.

Issues

Are the insurance carrier's reasons for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED."

28 Texas Administrative Code §133.10(f)(1)(O) requires that the billing claim form include the date of service. 28 Texas Administrative Code §134.204(j)(1)(D) requires that a narrative report accompanies the billing of an examination for maximum medical improvement and impairment rating. Review of the submitted information finds that the narrative report does not support the date of service billed. The insurance carrier's denial for this reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	April 20, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.